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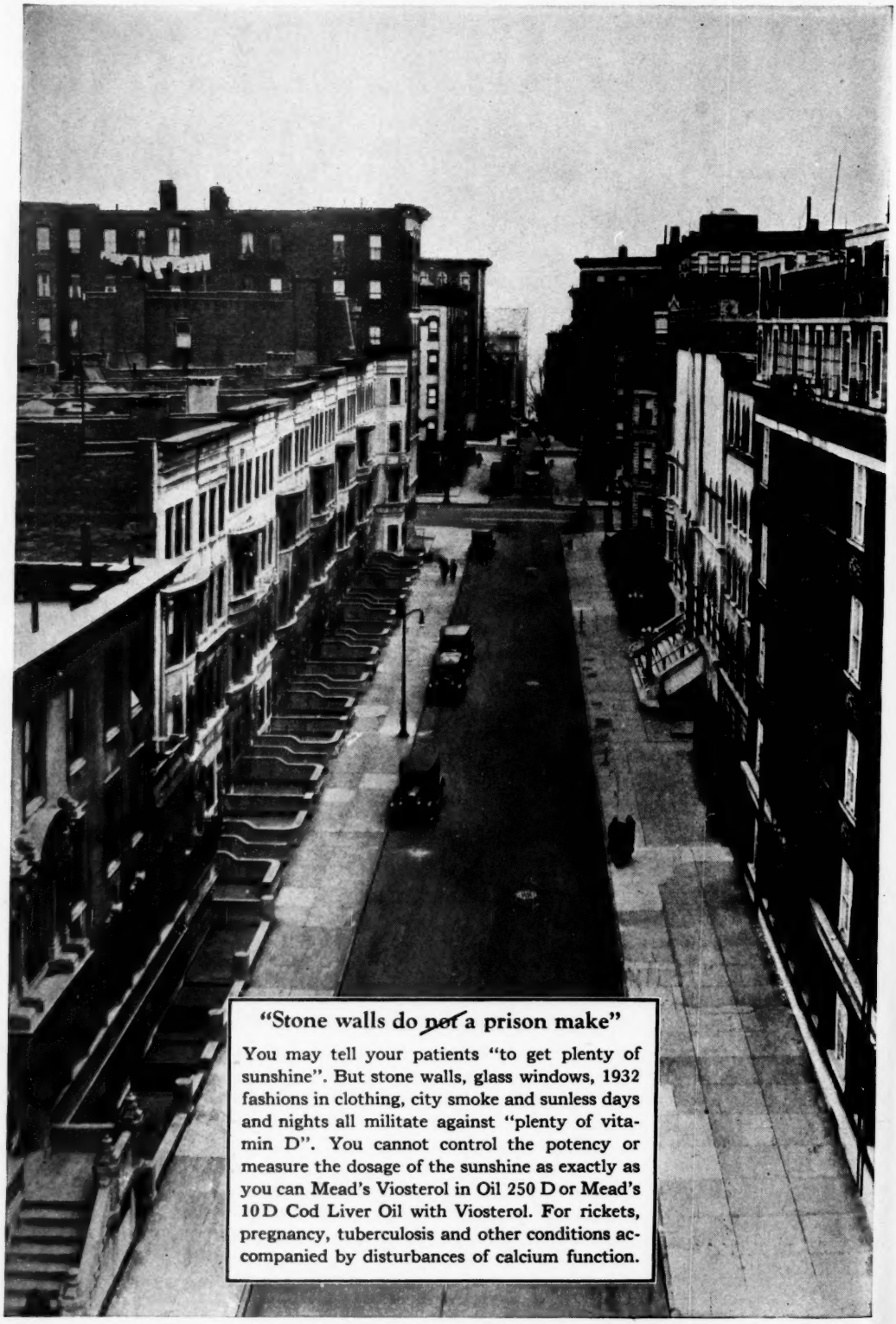
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ORIGINAL ARTICLES

RESUSCITATION

By ALBERT H. MILLER, M.D.

131 WATERMAN STREET, PROVIDENCE, R. I.

In "A New and Complete Dictionary of the Arts and Sciences, Printed for W. Owen, at Homer's Head, in Fleet Street, London, 1754," can be found the technic for resuscitation from drowning: "The great intention to be pursued is to put the solid parts of the machine in action, that thus they may restore the motion of the fluids; in order to do this, the drowned person should be agitated in various directions in the arms of persons of sufficient strength. One of the means frequently used with success, is to blow air, by means of a pipe, into their mouths, or to introduce it by a pair of bellows; or, by injecting warm clysters, to irritate the intestines; the smoke of tobacco conveyed into the intestines, by means of a tobacco-pipe, is much recommended. Venesection is by no means to be neglected; and perhaps most successfully in the jugular vein; and when all these measures prove unsuccessful, the last resort is bronchotomy."

Such was the status of resuscitation until in 1776, John Hunter invented a double bellows, one chamber for inflating the lungs and one for emptying them. The outlet of the bellows was introduced into one nostril while the other nostril and the mouth were kept closed. This apparatus became very popular and was recommended by the Royal Humane Society. Later it was found that it resulted in so much damage to the lung that its use was prohibited. This was the first of the mechanical resuscitators which have been introduced and intermittently used up to the present time.

In 1869, Silvester introduced the first of the manual methods of resuscitation. In the Silvester method, the unconscious patient is placed in the recumbent position with a pillow or pad under the shoulders. The operator stands or kneels above the patient's head and grasps both forearms just below the elbows. He draws the arms slowly and steadily outward and upward as far as possible above the head and holds them there for about two seconds. This motion expands the chest and produces active inspiration. The operator then brings the arms downward and presses the bent elbows gently but firmly for two seconds in front of the thorax. This movement causes forced expiration. The operator continues these upward and downward movements about fifteen times a minute until normal respiration is restored.

In normal respiration, inspiration is active and draws about 500 cc. of tidal air into the lungs. Expiration is passive, depending upon the elasticity of the chest wall. At the end of expiration there is a brief period of rest before beginning the next inspiration. At this point there remains in the lungs, 2600 cc. of reserve air. With the Silvester method, both inspiration and expiration are active. The first movement produces active inspiration. The second movement causes active expiration, during which some of the reserve air is expressed.

E. A. Schaefer, in 1906, introduced the prone pressure method of artificial respiration. The subject is placed in the prone posture, preferably on the ground or on the floor, with a thick pad under the chest and epigastrium. The operator kneels astride the patient, facing the head, and places his hands on the sides of the back over the lower ribs. He then slowly throws the weight of his body forward, keeping his arms extended, and thus forces air out of the patient's lungs. Then he gradually relaxes the pressure by bringing his own body up to the erect position but without removing his hands. The first movement causes forced expiration. Inspiration results from elasticity of the chest wall when the pressure is removed. The normal respiratory mechanism is reversed; expiration becomes active and inspiration passive, depending upon elasticity of the chest. Both inspiration and expiration affect entirely the reserve air.

These methods of artificial respiration are efficient as long as the chest wall retains its elasticity. With the prone pressure method it is possible to exceed the normal amount of tidal air.

In 1913, Meltzer recommended resuscitation by insufflation with oxygen or compressed air. He

developed an apparatus with a respiratory valve controlled by the operator and a safety valve set at 20 mm. of mercury, 10 inches water pressure. With the respiratory valve in the first position, the lungs were inflated to 20 mm. pressure. In the second position, positive pressure was removed and passive expiration resulted from elasticity of the chest. Insufflation was accomplished through an intratracheal catheter, a pharyngeal tube or a face mask. As in normal respiration, inspiration was the active movement and the tidal air alone was affected. Two cases of morphine poisoning with no spontaneous respiratory movement for at least twelve hours were successfully treated by this method.

Flagg has devised a modification of Meltzer's method, employing a cylinder of carbon dioxide mixture, a reducing valve, a water manometer which acts also as a safety valve, and an intratracheal tube. He introduces a direct vision laryngoscope, and through this aspirates any fluid which may be present in the mouth, pharynx or trachea. He then passes the intratracheal tube and produces rhythmical distension of the lungs by closing a finger valve located on the side of the outer end of the tube. When the finger is removed from this opening, expiration results from elasticity of the chest.

The method of resuscitation proposed by Meltzer was too simple and too efficient to make headway against two mechanical devices for artificial respiration which were extensively advertised—the Pulmotor and the Lungmotor.

The Draeger Pulmotor came from Germany in 1908. It was an ingenious automatic device worked by a cylinder of compressed oxygen. It inflated the lungs vigorously and then, reversing itself, drew the air from the lungs to the point of collapse. Many of the victims who temporarily survived this treatment died later from ruptured lungs. The Lungmotor was a double air pump worked by hand. It was not as deadly as the Pulmotor, but did not gain the Pulmotor's popularity because it was less impressive in operation.

Recently a mechanical device for artificial respiration has been produced from the laboratory of Western Reserve University. Working on the principle of the windshield wiper, it produces an intermittent flow, controls the rate and volume of flow and works automatically. It rhythmically distends the lungs and depends upon elasticity of the chest to induce expiration. The apparatus is efficient but somewhat complicated for use in the trying emergencies where resuscitation is required.

In March, 1929, Philip Drinker demonstrated in Providence, his Apparatus for Prolonged Artificial Respiration. The apparatus consisted of a stout metal chamber of sufficient capacity to hold the entire body except the head, a rubber collar to make an air-tight joint around the neck, and an air pump to alternately raise and lower the pressure in the chamber. He showed that a negative pressure of four inches of water was sufficient to cause inspiration and a like positive pressure to produce expiration. The present Drinker Respirator provides active inspiration, and allows expiration to result from elasticity of the chest wall as in normal respiration. Provision is made for active expiration if this should be required. The Respirator is a large steel chamber, one end of which can be entirely removed. The end plate is attached to a truck on which the patient reclines, with his head projecting through an opening in the plate and resting upon a pillow. A rubber collar is tightly clamped to the edges of the opening in the plate and is arranged to form an air-tight joint around the neck. The truck supporting the patient is wheeled into the chamber and the end plate is fitted closely to the chamber by means of clamps. Air is rapidly exhausted from the chamber by an air pump to a degree determined by an adjustable valve and indicated on a water gage. As the pressure in the chamber is reduced, the atmospheric pressure which affects the pulmonary alveoli through the patient's natural air passages expands the lungs and produces inspiration. When the negative pressure in the chamber is relieved, elasticity of the chest causes the expiratory movement. The degree of negative pressure required to produce satisfactory inspiratory movement is about four inches water pressure. A valve determines the rapidity of the respiratory movements which may be 15 or 30 times a minute. Satisfactory artificial respiration can be maintained by this method for days or weeks. Its principal use has been in treatment of poisoning as from overdosage with morphin and in treatment of the paralysis of anterior poliomyelitis.

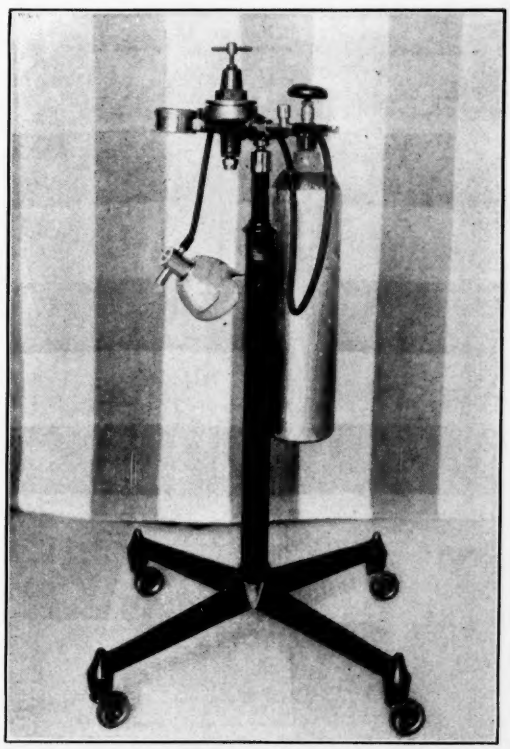
In 1912, Levi recommended the combination of carbon dioxide with oxygen for resuscitation in cases of gas poisoning. In fact, he suggested utilization of the respiratory acid-base balance for stimulation of respiration in resuscitation. Blood serum is normally alkaline. Acid waste products are constantly formed by metabolism, and, to retain

the blood in alkaline condition, must be constantly excreted by the urine, the feces, the perspiration and the respiration. On physical exertion, with increased acid waste products entering the blood stream, the blood serum, with diminished alkalinity, stimulates the respiratory center with the result that respiration is deepened and increased excretion of carbon dioxide quickly restores the normal alkalinity of the blood. If we artificially increase the carbon dioxide percentage of the inspired air, the alkalinity of the blood is lowered and the respiratory center is strongly stimulated to action. An increase of .2 per cent. in the carbon dioxide percentage of the alveolar air will double the volume of respiration. This is the principle underlying the operation of the modern Inhalator, the resuscitation device which has displaced the Pulmotor and the Lungmotor.

Commercial Inhalators, everywhere found in fire stations, police headquarters, in mines, electric light and gas plants and in industrial works, have the following features—cylinders of compressed Carbogen, which is a 5 or 7 per cent. mixture of carbon dioxide in oxygen; a reducing valve which reduces the tank pressure to about five pounds per square inch; a control valve calibrated in liters of flow per minute; a bag to hold a supply of gas; a safety valve to prevent undue distension of the lungs; an inspiratory leak to admit atmospheric air if required during inspiration; a hose connection and an inhaler with an expiratory valve. These inhalators do not provide for artificial respiration. They furnish a supply of carbon dioxide and oxygen mixture and rely upon one of the manual methods for the production of respiratory movements. The Schaefer method is the one recommended. The Inhalator provides, with considerable complication, a bag more or less completely filled with a mixture of carbon dioxide and oxygen, connected with an inhaler to be applied to the patient's face, an inspiratory leak and a safety valve.

The Schaefer prone pressure method of artificial respiration, upon which the operation of commercial Inhalators depends, is efficient, but may result in damage from prolonged kneading of the chest wall which a husky operator can effect. This treatment is mild in comparison to some of the methods to which infants are subjected in attempts to resuscitate the new-born. They are slapped and shaken, plunged alternately into hot and cold water, their chests kneaded in an effort to expel air which has never entered the lungs; they are even taken by the feet and swung through a wide circle. These methods of infant resuscitation show no improvement over the methods of 1754.

In the emergencies which require resuscitation, the factor which is most appreciated in an efficient apparatus is simplicity in operation. The apparatus which we use has been developed with this factor in mind, from the inhalator described by Dr. Yandell Henderson in the Journal of the A. M. A. of February 25, 1928. It utilizes a cylinder of 10% carbon dioxide in oxygen, a capillary opening, a safety valve and a face piece provided with an opening to be closed by the operator's finger and an inspiratory leak. The 10% mixture of carbon dioxide and oxygen is efficient and safe. The reducing valve serves also as a control valve. When set at 5 pounds pressure, it delivers about 5 liters a minute through the opening made by a No. 60 drill. The safety valve operates by gravity. A ¼-inch -



AN EFFICIENT INHALATOR

Operation requires only turning on the gas valve and setting the reducing valve at five pounds pressure. On applying the inhaler to the face with the finger valve closed, the patient's lungs are distended to a pressure determined by the weight of the ball in the safety valve.

opening is closed by a standard steel ball. By using balls of different sizes and weights, the valve may be arranged to open at any desired pressure. From four to eight inches water pressure are the usual limits. The valve is positive in action as long as it is kept in the upright position. It is more certain than a valve controlled by a spring, and does not require the attention demanded by a water gage. The purpose of the inspiratory leak which is located on the inhaler is to allow atmospheric air to be drawn in if the patient initiates normal respiratory movements. A breathing bag is not required.

In operation, the valve of the carbon dioxide oxygen cylinder is opened, the reducing valve set for five pounds pressure, and the inhaler is applied to the patient's face. On closing the outlet of the inhaler with the finger of the operator, the patient's lungs are distended to the pressure determined by the weight of the ball in the safety valve. The finger is then removed from the opening and the pressure is relieved. This procedure is repeated about fifteen times a minute. Closing the finger valve produces forced inspiration. Expiration is passive and occurs when the finger is removed from the outlet of the inhaler. In the small infant inhaler, the inspiratory leak and the outlet to the inhaler are omitted. The only requirement is to apply the inhaler to the infant's face and then remove it as often as required to produce respiratory movements. This apparatus produces active inspiration and depends upon the elasticity of the chest for expiration; it utilizes the effect of oxygen and the respiratory stimulation of carbon dioxide; and it is so simple in operation that it is efficient in emergencies.

In 1754, the field for resuscitation was confined to an occasional case of drowning. Under the conditions of modern civilization, the need for resuscitation is tremendously broadened. In addition to cases of drowning, there are the victims of electric shock and patients suffering from various forms of poisoning and from the effects of the deleterious gases to which the conditions of modern life bring us into proximity. There is poisoning from morphin, alcohol and ether; gases from the action of tetrachloride fire extinguishers—phosgene, hydrochloric acid gas and carbon tetrachloride vapor; gases from refrigerating plants—methyl chloride, sulphur dioxide and ammonia; gases resulting from conflagration, from burning celluloid films, from dynamite explosions or from spilling nitric acid—nitric oxide, nitrogen dioxide and nitrogen tetraoxide; there are petroleum vapors and carbon monoxide, the greatest hazard of modern life. For resuscitation of new-born infants, the inhalator displaces all the former crude methods of resuscitation and saves many lives which would otherwise be sacrificed.

Resuscitation, to be efficient, must be commenced within half an hour from the time when the heart beat ceases. The period of resistance to entire deprivation of oxygen to various tissues is as follows:

Cerebrum	8 minutes
Cerebellum	13 minutes
Medullary centers	20 to 30 minutes
Spinal cord	45 to 60 minutes
Sympathetic ganglia	1 hour
Mesenteric plexus	3 hours

Resuscitation is possibly effective thirty minutes after the heart has ceased to beat. It should be persisted in for another thirty minutes before losing courage. Infants have been resuscitated and have recovered when there had been no voluntary respiratory movements for two and a half hours. As long as the circulation is maintained, there is hope. When there is need for resuscitation, time must not be wasted in moving the patient or waiting for the arrival of an inhalator. Artificial respiration by one of the manual methods should be instituted as soon as possible and continued while the inhalator is on the way. When the inhalator arrives, it should be used even if respiration has been established by manual methods. The cases treated with carbon dioxide and oxygen do not develop the pneumonia which was the regular sequence of carbon monoxide poisoning before the introduction of the inhalator.

When artificial respiration must be performed for a long period of time, as in the paralysis of anterior poliomyelitis or in poisoning from morphin or alcohol, the Drinker Respirator is invaluable. It produces efficient artificial respiration over periods of days or weeks without strain on the operator or damage to the patient.

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COMMUNICABLE SORE EYES IN THE NEW-BORN*

By ANSON B. INGELS, M.D.,

Epidemiologist for the Rhode Island Public Health Commission

During the seven-year period from January 1, 1925, to October 27, 1931, 118 cases of communicable sore eyes in the new-born were reported to the office of the Rhode Island Public Health Commission. The follow-up on the reported cases showed two cases of total blindness; four blind in one eye and three cases where corneal scars were so situated as to interfere with vision.

For the seven-year period we thus have a yearly average of 17 reported cases with 1.3% of total or partial loss of sight.

In 1931 we have had nine cases reported. Five of these were delivered in institutions in the state; two by physicians; one by a midwife and one by a neighbor woman. Of these cases there is only one alibi to be entertained for the non-prevention of communicable ophthalmia in the new-born—that is the case of the neighbor called in and who, like the woman of Holy Writ, did what she could.

The incidence of this trouble, with the wreckage of blind and partially blind babies drifting, derelict in its wake, is extremely high in Rhode Island as compared with other states. Before going into statistics, however, I want to take up the microscopical findings in the cases reported for 1931 only. Ophthalmia neonatorum has come to mean, to the average physician, gonorrheal infection in the eyes of the new-born. This is not always the case, as the Koch-Weeks bacillus, the pneumococcus, staphylococcus, streptococcus, the organisms of the B. coli group are also found, while the staphylococcus albus and the diphtheroid bacilli—that is B. xerosis —are frequent normal inhabitants of the conjunctival sac. Also the diplo-bacillus of Morax is associated with sub-acute or chronic conjunctivitis—this particular bacillus at one time being associated in research work with trachoma.

During the course of the year our laboratories therefore get many smears from babies' sore eyes with requests to demonstrate the gonococcus. In our laboratories we do over 70,000 specimens per year, and have fifteen people including a mailing-clerk and a handy-man to do them, consequently our bacteriologists and technicians would ordinarily look for only such organisms as are requested, as time with them does not permit of extensive research work. Therefore in this year's cases we have two negative findings—the midwife's case and an infant delivered in one of the institutions—giving us a census of four positive gonorrheal eyes from institutions and two positive cases delivered by physicians. There is also a female in this group delivered at an institution reported as having a positive specific vaginitis as well as a gonorrheal conjunctivitis.

In final reports on the cases of 1931 to date, we have one cornea scarred and the others are reported as complete recoveries. I believe, however, that the conjunctiva or cornea is never normal after purulent infections.

Our Vital Statistics Department shows that to September 30, 8,500 living infants were delivered in the state in 1931. The morbidity reports show nine cases of communicable sore eyes and one specific vaginitis. The average births from 1925 to 1931 inclusive was 13,621 per year with 118 cases of ophthalmia in the new-born reported, or practically 100 cases to each 100,000 living births.

While Rhode Island reports will show this rate per 100,000 live births, Massachusetts for the same period shows six cases per 100,000 living births. New York state with 1,109,213 live births for five years, shows an incidence of 0.42 per 100,000, or less than two cases per each 200,000 live births. Connecticut, where a differentiation is made between gonorrheal and other ophthalmia of the new-born, reports 22 cases of specific ophthalmia in 159,000 births from January 1, 1926, to October 23, 1931, inclusive, or one case in every 7,227 live births. In 1931 there were two cases reported in 17,070 living births as against Rhode Island's six positive gonorrheal ophthalmia in 8,500 births in nine months, or one case to each 1,417 births in 1931. North Carolina in 1930 reported 14 cases out of 76,717 living births, or slightly over four cases per thousand births.

Tennessee, in the heart of the South, with its heavy mountaineer, negro and poor white population, where 60% of the infants are delivered without the assistance of either midwife or physician, reports one case of eye infection in each 1,011 live births. California reports one case per 4,000 births in the five-year period from 1926 to 1930 inclusive.

States from which statistics are quoted were picked at random, and you will note that many are

*Read before the Rhode Island Medical Society, December 3, 1931.

able to quote fractions of cases per hundred thousand births, while Rhode Island is able to report about one and one-half cases per thousand births over a six-year period, which would lead us to believe there was something wrong in our system of prevention in Rhode Island.

In the matter of prevention of communicable sore eyes in the new-born there are only three things to consider as causes of this difficulty:

First: The failure to instill a 1% solution of silver nitrate in both eyes immediately after the birth of the infant.

Second: Improper technique in the instillation of the solution in the eyes.

Third: The use of solutions that are decomposed by light or organic matter, and the use of solutions that are not standardized or solutions of unknown and untried germicides, where the findings of the manufacturers as published are not borne out by clinical tests.

Of the first cause the infant is protected by stringent laws of practically every state carrying heavy penalties for the non-use of a bacteriacide in the eyes of the new-born. Unfortunately, however, the fulfilling of the law is usually the physician's statement that such solutions have been applied. Physicians are also prone to take the statement of pharmaceutical manufacturers as absolute in the matter of proprietary germicides. These statements are not always borne out by impartial laboratory and clinical findings. Witness the passing of many popular so-called germicides that have had their day and been found wanting.

As to improper technique in the instillations: The author has a background of some years in country practice in regions where country practice in Rhode Island would be considered urban, and he therefore realizes the difficulties sometimes encountered by obstetricians in private homes in making applications to the eyes of the new-born with some inexperienced neighbor woman as an assistant. Patience and time usually overcomes the resistance of the crying infant.

In institutions and where there is proper assistance there is no reason for partial instillations, in spite of the hurry, and, it may be, lack of time or indifference of the accoucheur. Time being an element in the effective use of such germicides, they should be used immediately after birth, as delay oftentimes defeats the purpose of the germicides and giving the parasite time to lodge itself beneath the mucosa of the conjunctiva.

In the matter of faulty solutions: Mention has already been made of medicaments wrongly designated as germicides. The use of unknown and untried remedies of this character is, I believe, pernicious, particularly their use in the one application made in the prevention of communicable sore eyes in the new-born. Solutions for this purpose should be of known germicidal power, and I believe the use of such solutions should be regulated by law—the physician or obstetrician using the legal medications in the presence of a competent witness who will be able to certify that such solutions were used.

It has been determined that a 1% solution of nitrate of silver applied to the conjunctiva within twelve minutes of birth—that is, before the infective parasite has time to penetrate the mucous cells, will slay pathogenic organisms instantly. Fault has been found with silver nitrate owing to its escharotic effect, but in the absence of other tested and proven bacteriacides it will be advisable to use it in the strength noted. Solutions of heavy percentages sometimes leave a field for post-natal infections.

Solutions should be of known strength. The last chemical determination made of the solutions supplied by the Public Health Commission, and reported to me by our toxicologist on October 26, was 1.07%. Ampules supplied by us are checked at varying intervals and are thus kept at a standard percentage of solution. These are for free distribution to whoso comes, having authority to use them, without stint or hindrance, and without regard to race or creed.

By this method of distribution we hope to obviate the standard stock solutions, too often used, where evaporation renders the solution of too great strength, or contrariwise, precipitation of the silver content has occurred through contact with organic matter contained in swabs, etc. This also does away with stock solutions made without distilled water and called of indicated strength.

It is the author's belief that, with proper applications of effective medications, all cases of communicable sore eyes in the new-born can be prevented and the entire census of such cases should come from reported cases only where old women were accoucheurs, or where there is no one in attendance of an infected woman's labor.

*If the incidence of reportable cases of ophthalmia neonatorum should appear of a higher percentage than expected, it will be remembered that statistical requirements of this state are very exacting and respected—There is nothing the matter with Rhode Island.—(Ed.)

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EDITORIALS

"BASIC SCIENCES"

Under above caption, in another column of this JOURNAL will be found a transcription of a proposed Law. It is earnestly recommended to your attention; read it carefully, take time for it to be mentally digested and read it yet again for it has vital bearing upon a state's greatest asset—Health.

Disease has always been with us and probably will continue to be with us, but science and study year by year are robbing many diseases of their terrors exposing their secrets and ending their existence. Science, research and trained minds are doing away with misunderstanding as to causation and giving a clearer insight as to cure; but notwithstanding these established facts there are, and always have been, agencies that are constantly seeking to destroy the barriers, that for a century and more, necessity reared, not to protect the doctors, but the people themselves against the unskilled and the incompetent. Read this proposed law; be prepared to discuss it should occasion arise, satisfy yourself of its worth and be able to convince even the sceptics should you by chance come in contact with such.

Inasmuch as our Board of Public Health, after study of parellel laws of other states and existing conditions in this state, has sponsored this proposed law and that it has the emphatic approval of the House of Delegates of the Rhode Island Medical Society, it is our privilege and duty to consult our legislators and direct their attention to this humanitarian effort for the betterment of health of the people of Rhode Island.

THE NEED OF A BRONCHOSCOPIC CLINIC

This is not the first time these columns have voiced the need of a bronchoscopic clinic in these parts. Unless we err, there is none nearer than Brockton and Boston. Now the writer does not know whether there are the needful instruments at hand or those that are familiar with their use, and references to the advertising columns of this JOURNAL does not inform him: so, had he an urgent case or should someone stray into his office by mistake (of course) with a foreign body in the trachea or bronchus, or one in whom the X-Ray showed the need of investigation of the bronchi, he would be unable to place the patient to favorable advantage. We now have birth control "clinics," hay fever and asthma, goitre, and numerous other ditto, but no bronchoscopic facilities. Those who heard the lecture demonstration of Dr. Chevalier Jackson at Brockton last year must have been impressed with the frequent need of these trained specialists in every community, and the danger of delay in urgent cases. It cannot be supposed that this community is different from any other or that it enjoys any immunity from such emergencies, yet, as far as we know, it is very much behind the times in this phase of our surgical development.

The occasional need of the removal of neoplastic particles from the lung for diagnosis, and the subsequent cure of pulmonary carcinoma, has been stressed by Jackson, Pfahler and others, and this work cannot be done without bronchoscopic investigation. And it is to be believed that this JOURNAL would welcome the advertisement of any able and properly equipped man who wishes to be so known.

It is to be hoped that this plaintive plea will reach the ears of someone who will take the matter up and remedy what seems to be a defect in our ability to serve the needy public.

"PODIATRY"

In the absence of an old world nobility in this country, the only class distinction is between the educated and the uneducated. The natural result of public respect for higher institutions of learning and both baccalaureate and advanced degrees is therefore inevitable.

Equally obvious is the effort on the part of the underprivileged to imitate institutions and degrees in order to dignify less intellectual projects by the standards which we judge as college equivalents.

This would seem to be the only excuse for the existence of the New England College of Podiatry, with its elaborate and blatant catalogue listing a curriculum crammed with courses and burdened by "high-faluting" names which would seem to be wholly unintelligible in the old-fashioned trade of "Corn Doctor." It attempts to "Speak our language" through the subtle effrontery of degrees—"Academic," "Advanced," and even "Honorary." It boasts of "Fraternities," caps and gowns, and, of course, to the uninitiated, a presumably "imposing faculty."

Critical analysis of this catalogue leads one to suspect that it is a master effort in publicity propaganda to justify the wholly unreasonable tuition charges, in the exploitation of its students, lured by the impression that they are paying for a professional education.

Such is the genesis of cultism and the charlatan, for, judging by the history of previous cults, the Podiatrist will soon be ill satisfied with his limited field, and will branch out to conquer the entire medical horizon through the usual methods of political influence and legislation.

It would seem not only ill-advised, but extremely poor taste, for one who occupies the position of State Commissioner of Health, even though he be not a Doctor of Medicine, to allow his name to be published as a professor in such an undertaking.

Cults and quackery will always be with us, but they should not be encouraged by even quasi-medical support.

AN APPRECIATION
TO THE
PROVIDENCE MEDICAL ASSOCIATION

CHARLES VALUE CHAPIN, M.D., Sc.D., LL.D.

Your Committee, appointed at the December meeting of the Providence Medical Association to

prepare a Resolution in honor of Dr. Charles Value Chapin, recently retired as Superintendent of Health of this city, found itself in a quandary as to how best that assignment should be fulfilled. Our parent body, the Rhode Island Medical Society, had already adopted an admirable Resolution, insomuch that we could be but gleaners where the field had been closely reaped.

Our praise had thus been anticipated by a competent and sympathetic eulogist. Moreover, the medical and lay journals of Rhode Island have abounded in tributes of esteem, gratitude and affection to our distinguished and revered colleague. More than that, the RHODE ISLAND MEDICAL JOURNAL of March, 1927, printed a full report of the Testimonial Exercises in honor of Dr. Chapin, held in this building, when, on January 17th, 1927, at the unveiling of his portrait, we listened spellbound to a eulogy by one of the greatest of American orators, Dr. George E. Vincent, then President of the Rockefeller Foundation. The record of Dr. Chapin's exploits as sanitarian and scientist, as citizen of eminence, as man of sterling mental and moral qualities exactly suited to the work he had been called upon to perform,—that is an open book which all may read. In those circumstances, therefore, it has seemed to your Committee more fitting and possibly less embarrassing to Dr. Chapin himself, one of the most modest men, and never seeking "the blare and blaze of fame," to evade the restrictions of the conventional "Whereas" and "Resolved" and to submit for your approval and acceptance, in few words, the expression of our warmest congratulations on Dr. Chapin's resignation as a now accomplished fact. We wish him health, ease, peace and happiness in the new life upon which he has lately entered after fifty-three years of hard and unremitting labor in the profession that he has honored.

Charles Lamb, when he found himself no longer tied to a city desk, spoke of "the joy of walking about and around instead of to and fro," and Pliny the Younger, of "that indolent but agreeable condition of doing nothing." Our greatly esteemed and beloved colleague may now re-read to his heart's content, in slippered ease, the Essays of Elia as well as the writings of all Roman and other philosophers.

It was a philosopher of our own profession who three centuries ago remarked that "the long habit of living indisposeth us for dying." And the great desire of the ancient Jew that his days might be long in the land bore, as scientific commentators have observed, an obvious relation to the practice of those health laws according to which immunity from disease is secured and longevity encouraged.

So to Dr. Chapin your Committee would now say, as a last fervent word, in the name of this Society, in whose Medical Library hangs the image, by a master hand, of lineaments with which all of us are so agreeably familiar: "O King, live forever: let not thy thoughts trouble thee, nor let thy countenance be changed."

Respectfully submitted,
DENNETT L. RICHARDSON, M.D.,
G. ALDEN BLUMER, M.D.,
EUGENE P. KING, M.D.

CLINICAL-PATHOLOGIC CONFERENCE

Case reported by Dr. Eric Stone.

The following mimeographed history was passed out:

B. B. Male, 71.

P. H. Five years ago under treatment for two months for non-specific prostatitis which cleared up rapidly. One year ago operated elsewhere for ruptured appendix, made an excellent and complete recovery.

P. I. Two months ago began to have joint pains involving simultaneously and at different times the ankle, wrists, elbows and right shoulder. During this time felt weak and sick and had a daily evening temperature averaging 101. Nocturia 1-2. No burning, dysuria or diurnal frequency. Physical examination entirely negative except for oedema of both ankles, with tenderness over the malleoli and tenderness, but not swelling, at right acromio-clavicular joint and right wrist. The urine was normal but the prostatic fluid showed 100% pus.

Course. The patient could not be induced to enter the hospital for over a month, during which time the prostatic fluid cleared up well, and the daily swing of temperature dropped to 99, but the joints continued to disturb and the patient's general condition was getting worse. He was cyanotic, the oedema of the ankles increased, he appeared weak and shaky and looked acutely sick.

On admission the following laboratory data was obtained:

W. B. C. 22,000. R. B. C. 3,170,000. Hgb. 70%. P. M. N. 89%. A. M. E. 3%. P. M. B. 1%. Myelosytes 2%.

Blood chemistry: Urea N. 21 mg. Creatinine 1.3 mgm. Sugar 85 mgm. per 100 cc. of blood.

Urine, acid, 10.10; sugar negative; albumen trace; sediment showed a few w. b. c.

Blood culture: Sterile.

For the first two weeks in the hospital the patient did well, the joint disturbances, the oedema and cyanosis disappearing and the patient put on weight and felt much better. But the temperature rarely dropped to normal, the base line being at 99° with a daily swing to 102°. At the beginning of the third week he began to complain of right upper quadrant discomfort, also of frequency and burning on micturition. Pyelitis and subdiaphragmatic abscess was considered but could not be substantiated. X-Ray demonstrated no abscess and there was no C. V. T. and very few w. b. c. in the urine. While very marked for a few days, the urinary symptoms suddenly and spontaneously subsided. A week later he began to go down hill and the temperature base rose to 100° with the peaks at 104°. Although the only localizing symptom was the recurrent slight pain at times in the gall bladder region, he became steadily sicker. Toward the end of the third week the pulse which had for four days been rising gradually from its previous level of 70, jumped suddenly from 100 to 140 and remained there or above for two days, when he died.

During this time there had been no positive physical findings except for dullness at the base of the right lung. The prostate had become entirely normal. The heart was normal up to five days before death, when a systolic murmur was heard at the apex. A week before death the liver border became palpable, and in the last three days of life rapidly enlarged, the edge being felt four fingers below the costal border the morning on which he died. Death was cardiac. Three blood cultures were sterile. Repeated white counts showed w. b. c. increasing to 25,700, and the smears showed the same preponderance of P. M. N.

Dr. Turner: "I saw this patient on four or five different occasions. The prostate was that of a chronic prostatitis which did not feel like a carcinomatous prostate. Blood count of 22,000 is rather hard to explain away on the basis of a chronic prostatitis."

Dr. Wing: "I saw this patient several times and I remember at the time I could not get away from the thoughts that he might have pus somewhere. I thought it must be in the abdomen. As he went on one became more and more suspicious. I attended the postmortem examination and I was surprised."

Demonstration of Postmortem Material

Dr. Clarke: "I haven't any gross specimens, but I will show you the histology. The postmortem examination was limited to the abdomen only, so we cannot speak with any accuracy concerning organs elsewhere, although we did palpate the lungs. Heart, of course, was not examined. The organs of the abdomen, however, were quite interesting. The liver was noticed first, and it was thickly dotted with tiny yellowish grey areas, the largest ones being only about a m.m. in diameter, and from some of these could be squeezed out a little bit of grumous material. The spleen was almost identical with the liver. Scattered through it very thickly were these tiny greyish, apparently necrotic areas. The kidney shows a few nodules scattered through. There were rather large lymph nodes about the head of the pancreas and hilus of the liver. When these were sectioned, there were found scattered through these yellowish caseous material, and at the time of postmortem I think we were inclined to think we were dealing with miliary tuberculosis. We were quite puzzled when we saw the histology. I had never before seen anything like it. I called for help and I mailed sections from this case to Dr. Wolbach and Dr. Mallory. They answered:

> Dr. Wolbach: "The slides A-31-129 correspond perfectly with my ideas of tularemia and I should think that the brief account of the clinical history you gave is compatible. Not much has been written about the human pathology and these are the first tissues I have seen from a human case."
>
> Dr. Mallory: "A-31-129 may be a curious form of tuberculosis, perhaps of avian type. If you have not done so, I should certainly stain carefully for tubercle bacilli. Another possibility is that you have a case of tularemia. Unfortunately, it is not possible, so far as I know, to demonstrate the organism. One has to depend upon the serum test, and that, of course, is now impossible."

"We made acid fast stains of these lesions and were unable to demonstrate any organism. We then made gram stains and we found piled up in all of these small lesions a very small gram positive bacillus which looks more like a K. L. bacillus. It is not tularemia, because that is gram negative. After I had these stained I showed them to Dr. Wolbach and he agreed that it was not tularemia, but he had no idea what the organism was. I don't think we

can entirely rule out tuberculosis. A tubercle bacillus is gram positive and it is not always easy to get a positive acid fast stain in a tissue. We are unable to name the organism. We can only say that the man died of a bacterial infection, the organism being unidentified and the portal of entry being unknown."

DR. STONE: "I had several consultants for the patient, and their general opinion was a septicemia of some sort, and the interesting thing is the probable portal of entry of the bacteria. The only source was this very marked prostatitis. There was one hundred per cent. pus of the prostatic fluid when first seen. There seems to be a corollary between the bacteriology of this case and the more common phenomena of gonorrheal septicemia. In the latter, the gonococci are seldom found in the blood stream and not entirely because of difficulty in their isolation on culture media. Their absence is probably due to the fact that they lower the bodily resistance to other forms of bacteria, chiefly the staphylo and strepto-coccus groups.

"In the case under discussion, the original invading organism was a staphylococcus, localized in the prostate. However, during the period of septicemia these were never found in the blood stream. Our only lead to the organism being these unidentified bacilli found in the tissues."

SOCIETIES

THE RHODE ISLAND MEDICAL SOCIETY

A special meeting of the House of Delegates was called for Feb. 2, 1932, at 5 o'clock at the Medical Library by the President, Dr. H. L. Barnes, who presided.

The special business of the meeting was to consider a Basic Science Law proposed by the Public Health Commission of Rhode Island, and was presented by Dr. D. L. Richardson and Dr. Lester Round.

In a general way, the provisions of the Act comprehend the appointment of a State Board of Examiners in the Basic Sciences, namely—anatomy, physiology, pathology, symptomatology and diagnosis, chemistry, bacteriology and public health—which shall be appointed by the Public Health Commission and which shall examine in the Basic Sciences all persons seeking to practice any of the healing arts in this state. This examination must be passed by all candidates before they become eligible for examination by the various boards of professional examiners.

The Act as presented was taken up section by section, and thoroughly discussed by the delegates. Minor changes were suggested at the meeting and were accepted by the representatives of the Public Health Commission.

It was then moved by Dr. DeWolf, seconded by Dr. Jones, that the Act, as amended in accordance with the suggestions of the House of Delegates and approved by the representatives of the Public Health Commission of Rhode Island, be referred to the Committee on Legislation. So voted.

Adjourned.

Respectfully submitted,

J. W. LEECH, M.D.,
Secretary.

The proposed Act follows:

"BASIC SCIENCE LAW

"Section 1. No person shall be eligible for examination or permitted to take an examination for a license to practice any of the healing arts or any branch thereof, or granted any such license unless he has presented to the licensing board or officer empowered to issue such licenses a certificate of ability in (1) anatomy, (2) physiology, (3) pathology, (4) symptomatology and diagnosis, (5) chemistry, (6) bacteriology and (7) public health (hereafter referred to as the basic sciences) issued by the State Board of Examiners in the Basic Sciences (hereinafter referred to as the Board).

"Sec. 2. For the purpose of this act, any license authorizing the licentiate, by any means whatsoever, to diagnose, treat, operate or prescribe for or administer to any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal physical or mental condition is a license to practice the healing art.

"Sec. 3. Appointment of Board: The Public Health Commission shall appoint a Board of Examiners in the Basic Sciences consisting of not less than three members whose term of office shall be at the discretion of the Public Health Commission. No member of the Board of Examiners in the Basic Sciences shall be a member of the Public Health Commission or a member of any of the various professional examining boards. The mem-

bers shall be selected because of their knowledge of the basic sciences.

"Sec. 4. The Board shall meet as soon as practicable and organize by appointing one of its members as chairman and another as secretary and shall have power to adopt a seal which shall be affixed to all certificates which the Board may issue as provided by this chapter. The Board shall have power to make such rules and regulations as it deems expedient to carry out the provisions of this Act. The Board shall keep a record of its proceedings which shall be *prima facie* evidence of all matters contained therein. Each member of the Board shall receive ten dollars per diem as compensation for his services for each meeting attended and examination given. The compensation of members and other expenses of the Board shall be paid out of fees received from applicants.

"Sec. 5. The fees for examination shall be $10. The fees for re-examination within any twelve months' period shall be five dollars, but the fee for re-examination after the expiration of twelve months shall be the same as the original fee. The Board shall pay into the state treasury all monies received as fees to be placed in a special fund to the credit of said Board. The state treasurer shall pay out of such funds all expenses incurred by said Board upon presentation of vouchers signed by the chairman and secretary of the Board.

"Sec. 6. The Board shall conduct examinations at such times as it deems best, having due regard to the times and places of the examinations held by the several professional examining boards authorized to issue licenses to practice the healing art in the State of Rhode Island. Every applicant shall be examined to determine his knowledge, ability and skill in the basic sciences. The examination shall be conducted in writing. The presentation of a certificate of ability in the basic sciences, properly signed and bearing the seal of the Board of Examiners in the Basic Sciences, shall be a prerequisite to admission to examination before any board of professional examiners.

"Sec. 7. No certificate shall be issued by the State Board of Examiners in the Basic Sciences unless the person applying for a certificate submits evidence to the Board that (1) he is a person of good moral character; (2) he was graduated from an accredited high school or school of similar grade or possessed educational qualifications equivalent to those required for graduation by such an accredited high school, before he began the study of the healing arts; (3) he has a comprehensive knowledge of the basic sciences as shown by passing the examination given by the Board, as by this Act required; and (4) he has met the requirements of the general statutes as to professional training and the requirements of the particular examining board to which he wishes to apply for examination.

"Sec. 8. Any person, on account of having been previously licensed or registered to practice any branch of the healing arts, or any sub-division thereof, and who has been continuously in active and reputable practice in any other state of the United States or the District of Columbia, for a period of five years preceding application for admission to practice in this state, or on account of holding a certificate of the National Board of Medical Examiners, or on account of being a commissioned surgeon of the United States' army, navy, or public health service, desiring to be considered for examination by any of the various professional examining boards for admission to practice any branch of the healing arts, or any sub-division thereof, in this state, who shall submit to said Board of Examiners in the Basic Sciences evidence satisfactory to said Board that he is a person of good moral character, that he is a graduate of a standard approved high school or that he possesses educational requirements equivalent to those required for graduation by such a high school before he began the study of the healing arts and that he has met the requirements of the general statutes as to professional training and the rules and regulations of the professional examining board before which he wishes to appear for examination, and that he possesses a comprehensive knowledge of the basic sciences as defined in Section One of this Act, shall, upon payment of ten dollars, receive from said Board a certificate which shall be a prerequisite to the appearance of such person before any of the various professional examining boards on application for admission to examination as aforesaid.

"Sec. 9. No provision of this Act shall be construed as repealing any statutory provision with reference to the requirements for admission of applicants to examination by any of the various professional examining boards.

"Sec. 10. Fradulent Certificates Forbidden: Any person who shall obtain or attempt to obtain a basic science certificate by any dishonest or fraudulent means, or who shall forge, counterfeit, or fraudulently alter any such certificate, shall be fined not

more than five hundred dollars, or imprisoned not more than twelve months, or both in the discretion of the judge.

"Sec. 11. Exceptions: This Act shall not be construed as applying to dentists, nurses, midwives, optometrists, chiropodists, barbers, cosmeticians or Christian Scientists, practicing within the limits of their respective callings; nor to other persons licensed to practice the healing art or any branch thereof in this state when this Act takes effect, nor to persons specifically permitted to practice without licenses, practicing within the limits of the privileges thus granted them by the Public Health Commission.

"Sec. 12. This Act shall take effect immediately upon its passage."

Council Meeting

February 17, 1932.

The meeting of the Council was held at 4:30 P. M., Wednesday, Feb. 17, 1932, at the Medical Library Building. In the absence of the President, Dr. H. L. Barnes, the meeting was called to order by the First Vice President, Dr. N. Darrell Harvey.

The Secretary called the attention of the Council to the action of the telephone company in soliciting physicians to be listed in its directory under the heading of specialties. Apparently the agent of the telephone company made no attempt to verify whether or not the physician is entitled to classification of the specialty which he selected for this purpose. Several physicians through misinformation given them by the agent of the telephone company subscribed to the listing, and in one instance the company refused to accept a physician's request for the withdrawing of his name from such list. On motion of Dr. Christie, seconded by Dr. Keefe, it was voted that the Rhode Island Medical Society disapproves of its members being listed under specialties in the telephone directory as being contrary to the ethics of the profession, and that each member of the Society be notified of this action of the Council. It was so voted.

The Treasurer, Dr. J. E. Mowry, moved that Dr. John Ridlon, Dr. Charles V. Chapin, and Dr. A. H. Monty be placed on the retired list. Motion being duly seconded it was unanimously carried.

Adjourned.

Respectfully submitted,

J. W. Leech, M.D., *Sec'y*

House of Delegates

February 17, 1932.

The meeting of the House of Delegates was held at 5 P. M., Wednesday, Feb. 17, 1932, at the Medical Library Building. In the absence of the President, Dr. H. L. Barnes, the meeting was called to order by the First Vice President, Dr. N. Darrell Harvey.

The Secretary informed the House of Delegates of the action of the Council disapproving the listing of members of the Society under specialties in the telephone directory.

The Committee on Criminologic Institute, comprised of Dr. Wm. H. Magill, chairman, Dr. A. H. Ruggles, and Dr. H. A. Manchester, presented the following report:

"Report of the Committee appointed by the House of Delegates of the Rhode Island Medical Society, at a meeting held on Nov. 19, 1931, to confer with Dr. L. A. Round, Director of the Rhode Island Public Health Commission, with reference to the establishment or improvement of a so-called criminologic institute. This matter was brought to the attention of the State Society in a letter addressed to the Secretary, dated Aug. 14, 1931, which stated that at a meeting of the Board of Trustees of the American Medical Association held June 7, 1931, a report was submitted by the Committee on Medicolegal Problems urging the establishment of a criminologic institute in each state not already provided with such an agency for the detection and punishment of crime.

"A meeting of this committee was held Dec. 4, 1931, at the office of Dr. William H. Magill, the chairman. Dr. H. A. Manchester and Dr. A. H. Ruggles, the other members of the committee, were in attendance, and Dr. L. A. Round, Director of the Rhode Island Public Health Commission, and Mr. Benjamin M. McLyman, Attorney General of the State of Rhode Island, were also in attendance.

"A report of the Bureau of Legal Medicine and Legislation of the American Medical Association was read; also a report from the Medicolegal Committee of the American Medical Association. Discussion followed.

"None of those present knew of any criminologic institute in any state.

"Dr. Round reported that a toxicologist had been appointed to the State Board of Health and that forty-six cases had been examined in 1931, up to Dec. 1.

"Attorney General McLyman stated the need of closer co-operation between medical examiners and the Attorney General's office.

"Those present recommended the further development of the State Laboratory, and a conference between medical examiners and representatives of the State Board of Health and the Attorney General's department.

"Arrangements have been made between the Attorney General and the Director of the Rhode Island Public Health Commission to send out written instructions to each medical examiner, outlining a proper method of collecting and transporting specimens to be examined at the State Laboratory.

"It was agreed by those present that an effort should be made to provide a proper place in connection with the laboratory where autopsies could be performed and specimens taken and placed directly in the hands of the laboratory technicians for further examination.

"It was also decided that as soon as convenient the Attorney General would call a meeting of the medical examiners, the Director of the Rhode Island Public Health Commission, representatives from the Bureau of Criminal Identification for the State of Rhode Island, the state police, and the police departments of the cities and towns of Rhode Island, the object being to formulate plans along the lines suggested by the Bureau of Legal Medicine and Legislation of the American Medical Association and to co-ordinate all the resources we now have in this state for the investigation and detection of crime."

WILLIAM H. MAGILL, M.D.
ARTHUR H. RUGGLES, M.D.
H. A. MANCHESTER, M.D.

Dr. Magill stated that at the meeting which the Attorney General plans to call at an early date as referred to in his report, the committee would undoubtedly be asked to attend. It was voted to accept the committee's report with thanks for their painstaking and prompt action, and to continue the committee.

The Secretary stated that the Bureau of Legal Medicine and Legislation of the American Medical Association had requested that letters be sent from this Society protesting against the Bankhead Bill introduced in the national House of Representatives, and the Jones Bill introduced in the national Senate, both of which are for the purpose of the revivification and perpetuation of the Sheppard-Towner Maternity and Infancy Act. This latter act was repealed by Congress June 30, 1929. It was voted that the Secretary be authorized to send letters to the senators and representatives from Rhode Island protesting on behalf of the Rhode Island Medical Society against the passage of these two acts.

Adjourned.

Respectfully submitted,
J. W. LEECH, M.D., *Sec'y*

PROVIDENCE MEDICAL ASSOCIATION

The regular meeting of the Providence Medical Association was called to order by the President, Dr. Lucius C. Kingman, February 1, 1932, at 8:55 P. M. The records of the last meeting were read and approved.

The Standing Committee having approved their applications, the following were elected to membership: Vincent A. Cianci, Francis V. Corrigan, Gerald J. Curreri, Alice M. B. Eliot and Thomas H. Murphy.

On the motion of Dr. Jesse E. Mowry, it was voted to refer to the Standing Committee a proposition to subscribe $50.00 towards the expense of recovering leather chairs in the library.

The first paper was by Dr. Frederic C. Hussey on "Observations on a Few European Surgical Clinics." Dr. Hussey visited clinics in Switzerland, Italy, France, England and Scotland. He spoke interestingly of the work of the outstanding surgeons at these places, and gave his impressions of the clinics. He advised young Americans completing their studies to say in this country and only later in life to travel for surgical observation.

The second paper was by Dr. Herman A. Lawson on "A Medical Man in Porto Rico." He gave a short but interesting historical, geographical and sociological study of this small island, and then discussed the marked anemias common here due to the parasitical infestations and the deficient diets of the poorer classes. Dr. Lawson was a member of Dr. Castle's expedition there for the studying of these anemias.

Dr. Dennett L. Richardson, for the committee appointed at the December meeting, read an appre-

ciation of Dr. Charles Value Chapin, and it was voted to spread this on the records and send a copy to Dr. Chapin.

The meeting adjourned at 10:20 P. M. Attendance 130.

Collation was served.

Respectfully submitted,

PETER PINEO CHASE,
Secretary.

R. I. OPHTHALMOLOGICAL AND OTOLOGICAL SOCIETY

A regular meeting was held at R. I. Medical Library on Thursday, February 11, 1932, 8:45 P. M.

Subject: "Some Remarks on Chronic Mastoiditis," Dr. Frank M. Adams; "Current Operative Methods in Ophthalmology," Dr. Harry C. Messenger.

N. A. BOLOTOW, M.D.,
Secretary.

HOSPITALS

MEMORIAL HOSPITAL STAFF MEETING
HELD DECEMBER 10, 1931

Regular meeting of the Memorial Hospital Staff was called to order by President Charles H. Holt, M.D., at 9:15 P. M.

The minutes of the previous meeting were read and approved as read.

Two interesting cases on the Urological Service were presented by J. Edwards Kerney, M.D., Chief of the Service.

The speaker of the evening, Dr. Halsey DeWolf of Providence, chose as his subject, "Out-Patient Services." This paper referred particularly to the new method by which the O. P. D. services at the Rhode Island Hospital in Providence were conducted.

There was considerable discussion of the method as to its application to the O. P. D. at the Memorial Hospital.

Members present at the meeting were: Drs. Barr, Batchelder, Benjamin, Chapian, Chase, Cohen, Davis, Fox, Gillis, Greenstein, Hammond, Hacking, Henry, Holt, Jones, Kenney, Kerney, Saklad, Sargent, Sprague, Vandale, Wheaton and Win.

Meeting adjourned at 10:20 P. M.

STANLEY SPRAGUE, M.D.,
Secretary.

MEMORIAL HOSPITAL STAFF MEETING
HELD JANUARY 7, 1932

Regular meeting of the Memorial Hospital Staff was called to order by Dr. E. S. Wing at 9:20 P. M.

Minutes of the preceding meeting read and approved.

Dr. J. E. Kerney reported an interesting and unusual case on the urological service at a Providence Hospital.

Dr. Jay Perkins read a paper on "Some Observations on Endocrinology," speaking particularly regarding use of extracts of Pituitary Gland, Ovary and Testes. Discussion was opened by Dr. E. S. Wing and followed by Dr. J. E. Kerney, Dr. Ralph J. Petrucci, Dr. A. Vandale, Dr. Jacob Greenstein and Dr. Raymond F. Hacking.

Members present at the meeting were: Drs. Chapian, Davis, Goldberger, Gerber, Barr, Greenstein, Happ, Hanley, Hall, Hacking, Henry, Kechijian, Kelly, Kerney, Marshall, Moor, Petrucci, Sargent, Shaw, Sprague, Towle, Vandale, O'Neil and Wing.

Meeting adjourned at 10:40 P. M.

STANLEY SPRAGUE, M.D.,
Secretary.

PROVIDENCE LYING-IN HOSPITAL

The Providence Lying-In Hospital held its regular monthly staff meeting on January 14, 1932. Dr. Ira H. Noyes presented the report and interesting cases for the previous month. Dr. Robert M. Lord read a paper on the results of administering CO_2 and O_2 to premature infants for cyanosis for a period of two and one-half years. The results were very favorable.

Dr. Martin F. Buell completed his internship and is now at the Boston Dispensary as District Physician.

Dr. David R. Brodsky is now Resident Physician.

Dr. John D. Spring, who has completed his internship at the Springfield Hospital, Springfield, Mass., is now Junior Interne at the Providence Lying-In Hospital.

DR. EDWARD S. BRACKETT,
Secretary.

IMPORTANT NOTICE

THE PROVIDENCE TUBERCULOSIS LEAGUE

Dr. Jay Perkins, President; Dr. John I. Pinckney, Executive Secretary and Medical Consultant; Mrs. George H. Crooker, Secretary; Mr. George H. Capron, Treasurer. 100 North Main Street, Room 50, Providence, R. I.

February 3, 1932.

Dear Doctor:

The medical men of Providence have given this organization wonderful co-operation during the past year. For this, I wish you to know that we are deeply appreciative.

I am writing at this time to ask you to re-double your efforts, as the situation, from a tuberculosis standpoint, might easily become serious.

Through lack of employment many persons and their families are neglecting themselves because of their inability to pay for your services.

In view of this fact, we have decided, this year, to make a determined effort to examine as many of the known contacts in the city as possible, as it is from among this group the greatest number of secondary cases develop.

Undoubtedly you know of many such families, some of whom you may be visiting at the present time. We would deeply appreciate it if you would send in for examination and X-Ray those, at least, who are unable to pay.

The findings will be reported to you and the patient referred back to your office for further advice and treatment.

Sincerely yours,

JOHN C. PINCKNEY.

NOTICE

UNITED STATES CIVIL SERVICE EXAMINATION

The United States Civil Service Commission announces the following-named open competitive examination:

CYTOLOGIST

Applications for the position of cytologist must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than February 9, 1932.

The examination is to fill a vacancy in the U. S. Public Health Service, for duty at Boston, Mass. The duties will be to conduct research on the growth of normal and malignant cells in vitro; to study the morphology of cells; to co-operate in radiometric studies; and to conduct other studies in cytology as may seem advisable in connection with cancer investigations.

The entrance salary for the position now vacant is not to exceed $4,200 a year.

Competitors will not be required to report for training at any place, but will be rated on their education, training, and experience.

Certain specified education and experience required.

Full information may be obtained from the Secretary of the United States Civil Service Board of Examiners at the post office or customhouse in any city or from the United States Civil Service Commission, Washington, D. C.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination of the American Board of Obstetrics and Gynecology will be held in nineteen different cities of the United States and Canada at 2 P. M. on Saturday, March 26, 1932. The general, oral and clinical examination will be held in New Orleans on Tuesday, May 10, 1932, immediately preceding the meeting of the American Medical Association. Reduced railroad fares will be available. For detailed information and application blanks apply to the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pa.

DR. PAUL TITUS,
Secretary.

NOTE

AMERICAN COLLEGE OF PHYSICIANS TO AWARD PRIZE TO DR. O. T. AVERY

The American College of Physicians recently selected Dr. O. T. Avery of the Hospital of the Rockefeller Institute of New York City as the recipient of the John Phillips Memorial Prize for 1932.

This prize, an annual award by the College in the sum of $1,500.00, is given to perpetuate in the College the memory of Dr. John Phillips of Cleveland, a man of outstanding accomplishments as investigator, teacher and physician, for many years a member of the Board of Regents of the American College of Physicians, who gave his life in saving others on the occasion of the Cleveland Clinic disaster on May 15, 1929.

The Committee on the John Phillips Memorial Prize, through its chairman, Dr. James H. Means of Boston, recommends the award, "To Dr. O. T. Avery for the series of studies upon the Pneumococcus in which he has played a leading role, beginning with the discovery of the type-specific soluble capsular polysacchrides and culminating in the discovery of a bacterium producing an enzyme which splits the polysacchrides of Type 3 Pneumococcus in vitro, thus rendering it susceptible to phagocytosis and thereby protecting the animals infected with it."

The Sixteenth Annual Clinical Session of the College will be held in San Francisco during the week of April 4, 1932. Dr. Avery will deliver an address, "The Role of Specific Carbohydrates in Pneumococcus Infection and Immunity," at the Convocation on Wednesday evening, April 6. At the conclusion of Dr. Avery's address, the prize will be presented to him by Dr. S. Marx White of Minneapolis, president of the college.

The distinction of this award is enhanced by the fact that although it was available the previous year, it was not possible to decide on a suitable recipient. This is, therefore, the first award made. It is the hope of the officers and members of the college that this annual prize in memory of a distinguished colleague may, by recognizing merit, be a continuing stimulus to investigators in those subjects having a direct bearing on the advancement of clinical science.

BOOK REVIEWS

AN INTRODUCTION TO GYNECOLOGY. By C. Jeff Miller, M.D. Published by C. V. Mosby & Co., 1931.

Intended for use of beginning students in gynecology, this book deals concisely and with especial clearness with the various phases of the clinical course, pathology and diagnosis of gynecological conditions. The entire subject is brought up to date. The chapter on the glands of internal secretion is excellent and is particularly recommended to the practitioner because of the clearness of the presentation. The book is well illustrated throughout. The illustrations, although not original, are drawn from a variety of excellent sources and are well chosen to bring out the particular phases in diagnosis and pathology which the author desires to emphasize. Treatment is not taken up. On the whole the author has carried out his intention in a very workmanlike manner. We like the book and recommend it.

THE DIAGNOSIS AND TREATMENT OF BRAIN TUMORS. By Ernest Sachs, A.B., M.D., Professor of Clinical Neurological Surgery, Washington University School of Medicine. Illustrated. 396 pp. Saint Louis: C. V. Mosby Company.

On the twenty-fifth of November, 1884, Mr. Godlee of London removed a glioma about the size of a walnut from the right side of the brain of a living person, a patient of Hughes Bennett. The patient survived the operation only to die of septic meningitis a month later; the end result was very disappointing, but the demonstration that a tumor of the brain might be removed surgically was to have far reaching consequences. Seven years later, in a Fiske Fund Essay, Knapp collected statistics of all reported cases showing the removal of forty-six brain tumors and exploration without removal in twenty-six other cases. Forty of these patients recovered. In spite of this showing, Knapp, evidently expressing the informed opinion of his time, was very pessimistic regarding the future of brain surgery, and was moved to remark that "it is a self-evident proposition that those tumours alone are accessible to operation which are near the surface of the brain. **** The chance for operative treatment of cerebral tumour, therefore, is not great."

That the intervening years have not been without progress is most strikingly shown in the ability of a single surgeon to report a series of over two thousand operations for tumor of the brain; and it is further evidenced by the work of a steadily increasing group of neurological surgeons in this country. Dr. Ernest Sachs is a fitting spokesman for this group, and his book on the diagnosis and treatment of brain tumors gives a good picture of our present state of knowledge in this field.

The first chapter takes the anatomy and physiology of the brain from the standpoint of the surgeon, and there are interesting and very useful plates showing the surface relations of the important deep structures. This is followed by a description of the methods of examination used in American neurosurgical clinics. The surgical pathology of intracranial tumors is well handled, the work of Bailey and Cushing and of Penfield being followed in the main. How far we have travelled from Knapp's "self-evident proposition that those tumours alone are accessible to operation which are near the surface of the brain" is shown by the great amount of work which has been done on tumors of the pituitary gland, which is certainly not very close to the surface of the brain. An entire chapter is devoted to disorders of this gland and it summarizes, as well as it may be done at the present time, the conflicting evidence in regard to this fascinating physiological curiosity.

Operative technique is described in considerable detail and there are good illustrations to supplement the text. Electrosurgery is hailed as the greatest advance in this work since Horsley devised his bone wax and Cushing introduced his silver clips. Methods of approach to lesions in various parts of the brain have become fairly well standardized in the clinics of this country, and these standard procedures are well described. These methods, while they aim to secure the maximum of safety for the patient, are undeniably very time-consuming, it taking about an hour even to gain access to the brain. Some foreign operators, notably de Martel of Paris, use methods and apparatus which markedly reduce this time, and it is to be hoped that we may eventually adapt some of these methods to our own ideas of careful surgery.

Dr. Sachs' book can be recommended as giving a very good idea of the surgery of brain tumors as it is practiced in the United States at the present time.

MISCELLANEOUS

ROENTGENOLOGIC DIAGNOSIS OF APPENDICITIS

A. B. Moore and E. A. Merritt, Washington, D. C. (*Journal A. M. A.*, Nov. 14, 1931), enumerate in the order of their relative value, the roentgenologic signs of appendicitis thus: 1. Tenderness and muscular rigidity. This sign is produced by pressure directly over the appendix; it can be elicited only by palpation sufficiently deep to permit satisfactory exploration of the cecum, and it is the most important of all signs in this examination. While pain may be produced by pressure applied at a distance from the appendix, its point of maximum intensity should coincide with the viscus, and this localization must be definite and constant. If the appendix is mobile, the tender point changes with the altered position of the organ. 2. Fixation of the appendix. The normal appendix is freely movable and can easily be displaced by the palpating hand. When its position cannot be altered, it is indicative of an inflammatory process, either primary or secondary, active or quiescent. If fixation is accompanied by tenderness, unquestionably the process is either acute or subacute. Either the entire length of the viscus may be fixed or the process may be confined to the tip. When the appendix is situated in the pelvis there may be difficulty in separating it from the pelvic viscera; palpation with the patient in the Trendelenburg position will usually overcome this difficulty unless true fixation is present. Bimanual palpation, one hand on the abdominal wall and one in the posterior culdesac is sometimes of material aid in satisfactorily exposing a pelvic cecum. 3. Pain referred to the appendix, produced by pressure over other parts of the abdomen. This sign is based on the well known clinical principle of referred pain, the visualization and knowledge of the exact position of the appendix rendering it much more accurate. 4. Abnormal position of the appendix. 5. Spasticity of the cecum. 6. Pain referred to other parts of the abdomen, produced or increased by pressure over the appendix. This summary stresses the more salient points of the roentgenologic study of the appendix; their proper application furnishes a valuable aid both in discovering disease conditions and in excluding them, the latter being of equal if not of greater importance than the former. Microscopic study often fails to differentiate between an appendix that shows pathologic changes and one that produces clinical symptoms. The gross appearance of the appendix, as revealed by surgical exploration, and the future state of the patient's health constitute the best proof of the accuracy of the diagnosis. In those cases in which the advice of the roentgenologist has been followed, the results have been so satisfactory that the authors feel no hesitation in commending the procedure.